EXHIBIT 164

UNISYS - P.O. BOX 7082
TALLAHASSEE, FL 32314-7082

STATE OF FLORIDA
REQUEST FOR PAYMENT
FLORIDA MEDICAID PROGRAM
PHARMACY CLAIM FORM

1 ☐ A = ADJUSTMENT V = VOID

2 TRANSACTION CONTROL NUMBER

PHARMACY IDENTIFICATION, ADDRESS, & PROVIDER NUMBER
1097423 00

[redacted]

3 RECIPIENT'S NAME (LAST, FIRST, MI) [redacted]

4 MEDICAID I.D. NUMBER [redacted]

6 5 DRUG GRANT ADJUSTMENT

7 YES ☐ OTHER PRESCRIPTION INSURANCE?

LINE NUMBER										
0	REMARKS	9A Rx NUMBER 177780	10A MANUFACTURER CODE 00469	ITEM 2492	PKG. 5	11A QUANTITY 10	12A DAYS SUPPLY 1	13A PRESCRIBER'S FLORIDA DPR LICENSE NUMBER ME0036940	14A CERT.	15A DATE FILLED 06 25 97	16A O/R R	17A AMOUNT BILLED $ 5 00
1	REMARKS	9B Rx NUMBER 177711	10B MANUFACTURER CODE 57317	ITEM 0216	PKG. 06	11B QUANTITY 1	12B DAYS SUPPLY 1	13B PRESCRIBER'S FLORIDA DPR LICENSE NUMBER ME0036940	14B CERT.	15B DATE FILLED 06 25 97	16B O/R R	17B AMOUNT BILLED $ 98 25
2	REMARKS	9C Rx NUMBER	10C MANUFACTURER CODE	ITEM	PKG.	11C QUANTITY	12C DAYS SUPPLY	13C PRESCRIBER'S FLORIDA DPR LICENSE NUMBER	14C CERT.	15C DATE FILLED	16C O/R	17C AMOUNT BILLED $
3	REMARKS	9D Rx NUMBER	10D MANUFACTURER CODE	ITEM	PKG.	11D QUANTITY	12D DAYS SUPPLY	13D PRESCRIBER'S FLORIDA DPR LICENSE NUMBER	14D CERT.	15D DATE FILLED	16D O/R	17D AMOUNT BILLED $
4	REMARKS	9E Rx NUMBER	10E MANUFACTURER CODE	ITEM	PKG.	11E QUANTITY	12E DAYS SUPPLY	13E PRESCRIBER'S FLORIDA DPR LICENSE NUMBER	14E CERT.	15E DATE FILLED	16E O/R	17E AMOUNT BILLED $
5	REMARKS	9F Rx NUMBER	10F MANUFACTURER CODE	ITEM	PKG.	11F QUANTITY	12F DAYS SUPPLY	13F PRESCRIBER'S FLORIDA DPR LICENSE NUMBER	14F CERT.	15F DATE FILLED	16F O/R	17F AMOUNT BILLED $

18 TOTAL AMOUNT BILLED $ 103 25

18 PRINT OR TYPE UNUSUAL AND COMPOUND PRESCRIPTION INFORMATION BELOW WITH LINE NO.

FORMER TCN FOR RESUBMITTAL OF PREVIOUSLY DENIED CLAIM

IMPORTANT
READ CERTIFICATION STATEMENT ON THE REVERSE SIDE.
I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

AUTHORIZED SIGNATURE / TITLE

7/14/97
BILLING DATE

FOR OFFICE USE ONLY

061 7/94

0017906

VACMDL44051

VAC MDL 44051

P-00323

[redacted]

k

State of Oklahoma
Oklahoma Health Care Authority

Prescription Drug Claim Form

PLEASE PRINT CLEARLY

Provider Number (required)	Loc (req)	Billing NPI (optional)	Telephone Number
01	02	03	04

Patient's Name: Last, First (required)	Member ID (Required)	Member's Date of Birth (Required mmddccyy)	Emergency (Y or N)	Pregnancy (Y or N)	NH Rc (Y or N)
05	06	07	08	09	10

Prescription Number (Required)	Date Prescribed (Required)	Date Dispensed (Required)	NDC Number (Required)	Quantity (required)	Days
11	12	13	14	15	16

Brand Medically Necessary	Refill	Individual Prescriber's NPI Number (Required)	Individual Prescriber's Name: Last, First (Required)
17	18	19	20

Provider's Name and Address	This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law. I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.	
25	Signature of Provider or Representative (Required) 26	Date Billed (Required) 27

Charge (Required)	Third Party Paid	Total Amount Billed (Required)	Usual and Customary
21	22	23	24

Mail Completed Claim Form to:
EDS
P.O. Box 18650
Oklahoma City, OK 73154

PHARM-1

DEY-SUB-OK-0000013

Medicaid Provider Manual

APPENDICES	Section No(s). : Appendix 11R
MEDICAID CLAIM FORM INSTRUCTIONS	Trans. Bulletin:
Prescription Drug Claim - Form 204	Revision Date : July 1987
	Prev. Rev. Date: February 1976

[redacted]

HAWAII MEDICAL SERVICE ASSOCIATION, FISCAL ADMINISTRATOR
HAWAII STATE MEDICAID (Title XIX) PROGRAM
P.O. BOX 860, HONOLULU, HAWAII 96808
PRESCRIPTION DRUG CLAIM

1 | 2 | HMSA MEMBERSHIP NUMBER 3 | 4 | M | SP | S | D | HMSA COPY | 9 DATES DISPENSED

IDENTIFICATION NUMBER 5a | GRP NUMBER 5b | COND 5c | COV 5d | PLAN CODE 5e | PATIENT'S LAST NAME, FIRST NAME, MI 6 | 7 SEX F M | BIRTHDATE MO DAY YR 8 | FROM MO DAY | TO MO DAY

SUBSCRIBER OR CASE NAME 10 | UNIT 11 | PROVIDER OF SERVICE 12 | PROVIDER NO 13 | PRI DIAG 14 | SEC DIAG

ADDRESS 15 | WORKER 16 | ADDRESS IF NOT IN THE STATE OF HAWAII: 17 | B1 B2 B3 B4 B5 B6 18

CITY | STATE | ZIP CODE | B7 B8 B9 B10 B11 B12

COMPLETION REQUIRED

OTHER DRUG OR LIABILITY COVERAGE? ☐ YES ☐ NO | DATE OF ACCIDENT MO DAY YR 20 | IS THE ILLNESS OR INJURY: WORK RELATED? ☐ YES ☐ NO | THIRD PARTY? ☐ YES ☐ NO

NAME OF CARRIER: 19 | AUTOMOBILE? 21 ☐ YES ☐ NO | OTHER ACCIDENT? ☐ YES ☐ NO

IS PATIENT IN SNF/ICF? 22 ☐ YES ☐ NO | IS THERE A DIAGNOSIS? 23 ☐ YES ☐ NO | IF YES, DIAGNOSIS 24 | AUTHORIZATION NO. 25

PRESCRIBED BY (LAST) (FIRST) (MI) 26 | PHYSICIAN NO. 27

	RX NUMBER	NEW / REFILL	MANUFACTURER NO	PRODUCT NO	SIZE	NAME STRENGTH OF DRUG	IF COMPD	MANUFACTURER	QUANTITY	DATE DISPENSED	CHARGES	DAYS SUPPLY	BRAND YES/NO	MEDICAID ONLY
1	28 29		30			31	32	33	34	35	36	37	38	39
2														
3														
4														

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws. I hereby agree to keep such records as are necessary to fully disclose the extent of service provided under the State's Title XIX plan and to furnish such information regarding any payments claimed above as the State agency may request.

SUB TOTAL	40
TAX	41
	42
TOTAL CHARGE ▶	43

44 PROVIDER'S SIGNATURE | 45 DATE

1400352